

City of Amarillo Group Health Plan January 2011

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Welcome to the City of Amarillo's Group Health Plan!

This summary plan document provides the information you will need to maximize your benefits and answer questions regarding your group health benefits. Please read the information carefully before making any enrollment decisions. If, after have read the information, you have any questions, call the Benefits office at (806) 378-4235. The Benefits office is located in the basement of City Hall at 509 S.E. 7th Avenue, Amarillo, Texas. Health plans can be confusing. The Benefits office staff is here to help you so don't hesitate to call or drop by with any questions or concerns.

The City of Amarillo's Group health Plan is a managed care plan.

This means the City has contracts with a network of healthcare providers to offer quality healthcare services in a cost effective manner to covered employees, dependents and retirees. The City does not limit you to the providers within the network, however, there are advantages when you choose a network provider. These advantages are discussed in detail throughout the handbook. A list of network providers is included.

Remember this is your benefit.

Familiarize yourself with the Plan's design in order to convey the correct information to your healthcare provider. In this way you can partner with your provider to insure quality medical care while maximizing your benefits under the Plan.

This summary plan document is not a contract.

It explains in simple language the essential features of your health, dental and flexible spending benefit plans as governed by the Plan documents on file in the Benefits office. All your rights and benefits are determined solely by the provisions of the Plan documents with the exception that the Plan documents may be superseded by applicable State and Federal regulations. The City has the right to change, edit, modify and/or clarify the Plan at its discretion. The benefit amounts may increase or decrease depending on the City's ability to contract for services and the annual appropriations for benefits by the City Commission.

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ENROLLMENT INFORMATION

The City of Amarillo provides participants with a health care benefit plan that provides financial protection from significant health care expenses and assures quality care. The City of Amarillo's Group Health Benefit Plan ("Group Health Plan") is a managed care plan. The City of Amarillo has contracts with a network of healthcare providers to offer quality healthcare services in a cost effective manner to covered employees, dependents and retirees. The Group Health Plan does not limit the covered member to the providers within the network, however, there are advantages when a network provider is chosen.

Enrollment Information: All full time Regular Employees of the City of Amarillo and Related Affiliates, Eligible Independent Contractors and retirees and their eligible dependents may participate in the Group Health Plan. Eligible dependents include the following:

- a) a lawful spouse;
- b) natural children through age 25
- c) stepchildren through age 25;
- d) legally adopted children through age 25;
- e) foster children through age 25
- f) unmarried grandchildren through age 25 who are dependents of the covered member for federal income tax purposes at the time coverage is requested;
- g) other children through age 25 for whom the covered member is legal guardian or conservator;
- h) a retiree's widow/widower (see Coverage as a Retiree);
- i) the widow/widower of an employee who is eligible to retire at the time of death (see Coverage as a Retiree);
- j) a retiree's divorced spouse who was covered under the Group Health Plan immediately prior to January 1, 2011 (see Coverage as a Retiree); and
- k) the divorced spouse of an employee who was eligible to retire at the time of divorce and such divorced spouse was covered under the Group Health Plan immediately prior to January 1, 2011 (see Coverage as a Retiree).

Children over the age limit may be considered eligible dependents if:

- the child is incapable of making a living due to mental or physical disability on the day before reaching the age limit (the Group Health Plan may require a physician's statement certifying the physical or mental disability); and
- is dependent on the covered member for more than half of his or her support; and
- has been continuously covered by the Group Health Plan.

**Dependent children who meet the above criteria and are covered by parents, who are retirees, may continue to carry retiree coverage, upon the death of one or both parents.

Notwithstanding the foregoing, for Plan Years beginning before January 1, 2014, an adult child eligible to enroll in another eligible employer-sponsored plan is not eligible to participate in the Group Health Plan.

Active employees and/or dependents who are eligible to participate in the Group Health Plan, but choose instead to participate in another employer's group health plan, may, participate in the Group Health Plan if enrollment occurs within 90 days of the date coverage under the other plan ends, if the termination of coverage is due to the death of a spouse, loss of a spouse's job or a divorce from a spouse. At the time of enrollment in the Group Health Plan, a termination notice must be submitted from the prior plan. All limitations, provisions and requirements of the Group Health Plan are effective upon enrollment.

When Coverage Begins

When the enrollment requirements are met, eligibility for coverage begins on the 90th day following the enrollee's employment date, if the enrollee is actively at work. Coverage for the enrollee's dependents begins the latest of the enrollee's coverage date or the first day of the pay period following enrollment of a legally acquired dependent.

Coverage Information

Eligibility for health coverage begins on the 90th day following your date of employment, if you are actively at work.

Coverage for your dependents begins on your coverage date or the first day of the pay period following enrollment of a legally acquired dependent. Copies of marriage license and birth certificates are required to add dependents to the coverage.

Coverage terminates on the earliest of:

- The last day of the pay period in which employment with the City of Amarillo ends
- The date you or your dependents cease to be eligible

A terminated employee has 60 days from the date coverage ends under the Plan to elect COBRA coverage. Premiums for COBRA coverage are paid through the Accounting Department and must be paid regularly or coverage will end. Election notices are sent by the Benefits office upon termination of employment. See Continuation of Coverage (COBRA) information beginning on page 48.

You are allowed to make changes to your health plan coverage once a year during the open enrollment period.

Certain life change events allow changes to be made at other times. Marriage, divorce, loss of a job which causes a spouse to need insurance coverage, birth or adoption of a child are a few examples of a life change event which could cause you to apply for a change in your coverage. Proof of the life change event is required, i.e. birth certificate, divorce decree.

Section 125 of the Internal Revenue Service code establishes time limits for allowable changes during the year.

- 90 days from the date you obtain a dependent by marriage, birth, adoption, etc. to add the dependent
- failure to add the dependent within the 90 days means the dependent cannot be added until the next open enrollment period
- 90 days to drop a dependent once he/she becomes ineligible - if you fail to notify the Benefits office within the allowed time, the dependent will be dropped and no refund of premiums will be paid

Newborns must be added within 30 days to be covered from birth.

Employees on approved unpaid leave of absence (approved by the City Manager), Family Medical Leave of Absence (FMLA), or worker's compensation leave, may continue coverage for the duration of the approved leave if required contributions are paid. Failure to make a required payment, within 30 days of the due date, will result in the City stopping payment to providers for those services incurred during the time payments are in default and cancellation of coverage/services. Employees who return to work may reinstate benefits during the annual open enrollment period, provided any outstanding balances toward the cost of the coverage have been reimbursed. Contact the Benefits Administrator at 378-9379 for more information.

Employees on military leave see USERRA information on page 60

Retiree Coverage

Each employee who has ten (10) years of full time service with the City of Amarillo or a Related Affiliate and is eligible for service or early retirement, or qualified for a disability retirement under the Texas Municipal Retirement System (TMRS), the retirement plan sponsored by Amarillo Economic Development Corporation (AEDC), or the Fireman's Relief and Retirement Fund (FRRF) may continue coverage in the Group Health Plan as a retiree, at the time he or she terminates service with the City of Amarillo. An eligible retiree may elect coverage for his or her dependent or dependents (determined at the time of his or her termination of service with the City of Amarillo for dependents other than children of the retiree younger than age 26). If an eligible retiree desires this continued coverage, he or she must notify the City of Amarillo within thirty (30) days of his or her termination of service with the City of Amarillo. If a retiree, who is receiving retiree health coverage because of a disability, becomes ineligible for disability retirement, that retiree will not be eligible for continuation of coverage in the Group Health Plan.

Each employee who is covered under the Group Health Plan, suffers a bona fide injury while on duty with the City of Amarillo, permanently unable to perform the duties of his or her position due to such workers' compensation bona fide on-the-job injury/illness, and qualifies for a disability retirement under the Texas Municipal Retirement System (TMRS) , the retirement plan sponsored by AEDC, or the Fireman's Relief and Retirement fund (FRRF), may continue coverage in the Group Health Plan as a retiree. The applicable retiree rate for such injured and disabled employee with less than 20 years of service will be based on whole years of service as determined by dividing 20 years of service minus the employee's actual years of service with the City of Amarillo by two and adding back to this result the employee's actual years of service (any fractional years of service determined under the preceding formula shall be rounded downward). The applicable retiree rate for an injured employee with 20 or more years of service will be based on actual years of service with the City of Amarillo.

A widow/widower, of an employee who has ten (10) years continuous and uninterrupted service with the City of Amarillo who at the time of death *is eligible to retire* as specified above and at the time of death, the widow/widower is covered by the Group Health Plan, may continue coverage under the Group Health Plan at the applicable retiree premium rate.

The divorced spouse of an employee who has ten (10) years continuous and uninterrupted service with the City of Amarillo, who at the time of the divorce *is eligible for retiree coverage* as specified above and at the time of divorce is covered by the Group Health Plan, may continue to be covered by the Group Health Plan at the applicable retiree premium rate. Only one ex-spouse per employee may continue retiree coverage under the above conditions.

The widow/widower or divorced spouse of a retiree who has coverage as a **retiree** under the Group Health Plan may continue coverage as a retiree.

Retiree coverage begins the first day an eligible active employee ceases employment with the City of Amarillo.

Notwithstanding the foregoing, effective January 1, 2011, no divorced spouse of a retiree, employee or former employee who is not already receiving coverage as a retiree under the Group Health Plan immediately prior to January 1, 2011, shall become covered under the Group Health Plan on or after January 1, 2011.

No **retiree** may add a spouse or dependents (other than children of the retiree younger than age 26) to the Group Health Plan after date of retirement.

Total municipal service will be considered (including service time with other cities) in determining the retiree rates. However, service time with other cities will not be considered in determining health coverage eligibility. Moreover, military service time and service time with other governmental entities will not be considered in determining eligibility or in determining the applicable retiree rate which are based on service.

When both spouses in a marriage are employed by the City and one retires while the other continues employment with the City, the retiring spouse will make one of the following irrevocable elections concerning health plan coverage:

- a. The employed spouse remains on active coverage under the Group Health Plan at the applicable active employee rates.
 - i. if the employed spouse separates from service with the City prior to the death of the retired spouse, the employed spouse is required to meet the retiree eligibility requirements to be eligible for retiree coverage upon the employed spouse's separation from service or;
 - ii. if the retired spouse dies before the employed spouse separates from service with the City, the employed spouse may elect to either (A) remain on active coverage under the Group Health Plan at the applicable active employee rates and is required to meet the retiree eligibility requirements to be eligible for retiree coverage upon the employed spouse's separation from service or (B) be covered under the retiree coverage at applicable retiree rates (and, thus, would not be required to meet the retirement eligibility requirements upon the employed spouse's separation from service);
- b. The employed spouse is covered under the retiring employee's retiree coverage at applicable retiree rates (and, thus, would not be required to meet the retirement eligibility requirements upon the employed spouse's separation from service).

When a retiree is Medicare eligible the City Group Health Plan becomes a supplement to Medicare. Retirees must take Medicare coverage, if eligible, to continue coverage under the City's Group Health Plan.

Coordination of Benefits

If you, your spouse or your dependents are eligible to receive benefits under another plan, some items may be covered under both plans. If so, the plans will coordinate payment of benefits. This means the primary plan will pay the incurred charges first as the plan allows. The

secondary plan will pay the remaining amount as allowed. No more than 100% of the allowable expenses incurred will be paid by all plans.

The City's Plan will always be primary for its employees. Primary coverage for dependent children is determined by the "birthday rule". This means whichever parent's birthday, month and day, not year, falls first in the calendar year determines primary coverage for the dependent.

Example: Your birthday is in February and your spouse's birthday is in August, your health plan will be primary for your dependent children. If both birthdays are the same, the plan, which has covered the dependent longer, pays as primary.

Please call the Benefits office at 378-4235 if you have coordination of benefits questions.

Schedule of Benefits

ANNUAL DEDUCTIBLE
(Calendar year, January 1-December 31)

Individual \$ 800.00

Family **\$1,600.00****

**Must be met by more than one covered person in the family and one person may not meet over \$800.00.

Annual Out-of-Pocket Amount (Calendar year, January 1-December 31)

Individual	\$2,600.00
Family	\$5,200.00**

**Must be met by more than one covered person in the family and one person may not meet over \$2600.00.

Expenses that do not apply toward deductible or out-of-pocket amounts:

- any amounts which are ineligible according to the Plan's payment schedule
- any penalty for failure to precertify mental health services
- the per admission penalty deductible for using a non network hospital
- any penalty for failure to precertify hospital and outpatient surgery
- any penalty for failure to precertify additional hospital days
- prescription drug co-payments

Expenses for treatment of outpatient mental/nervous disorders apply toward the deductible but not the out-of-pocket. These expenses are never paid at 100%.

The Plan will pay 80% of eligible charges and the covered member will be responsible for 20% of the eligible charges after deductible amounts are met. When the above deductible and out-of-pocket amounts are met, the Plan will pay eligible charges at 100%.

Maximum Plan Benefits

- Chiropractic treatment

Lifetime maximum	\$5,000
Annual maximum	\$1,000

Pre-Existing Conditions

A pre-existing condition is any illness or injury for which diagnosis, consultation or treatment has been received during the 3 months prior to the effective date of coverage.

Benefits for expenses related to pre-existing conditions are limited to \$750 during the first 12 consecutive months of participation in the Plan.

Notwithstanding the foregoing, there is no pre-existing limitation for children enrolled in the Group Health Plan who are under the age of 19.

Wellness Benefits

State mandated immunizations will be paid at 100% for children birth to age 6 regardless of deductible.

The Plan will allow 7 well baby visits from birth through 12 months with a \$25.00 copay regardless of deductible. During the second year, 13 months through 24 months, the Plan will allow 3 well baby visits with a \$25.00 copay.

The first \$100.00 of wellness charges per year (annual physical exams, well-child visits after 24 months of age) will be considered as regular claims subject to deductible and co-payments. Wellness charges exceeding \$100.00 are not eligible expenses.

The Plan will pay 100%, without regard to deductible, for one screening mammogram per year for women age forty (40) and over at a network provider. Mammograms may also be scheduled during Harrington's annual onsite testing at City Hall.

The Plan will pay 100%, without regard to deductible, for an annual Prostate Specific Antigen test and a digital rectal exam, for men age fifty (50) and over.

The Plan will pay 100% for a City of Amarillo sponsored weight loss program for those individuals who have a Body Mass Index (BMI) of 30 or greater as documented by program personnel or a personal physician. If the program is not completed, the individual will be required to reimburse the City for program costs.

Claim Information

Filing Claims

All health care benefits are paid from claims (bills) submitted by the employee or medical provider. All claims are paid according to the date they are received in the Benefits office. From the date of service, the Plan has a 90 day filing deadline. Any bills received after the 90 day filing deadline will be denied for payment. Please advise your provider.

Important: *If you want payment made directly to the provider, sign the assignment portion of the itemized bill, otherwise payment is made directly to you.*

Appealing Denied Claims

If a claim for benefits is wholly or partially denied, an explanation of benefits (EOB) is sent to the covered employee and the provider explaining why the claim was denied. Appeals must be made in writing to the Plan Benefits Administrator and received in the Benefits office within 90 days of receipt of the EOB denying the charges. You should include any relevant information from the healthcare provider with your appeal.

When applicable, the Plan Benefits Administrator will submit the claim and the appeal to the Plan's Medical Director for review and recommendations or, if needed, the claim will be reviewed by the Plan's Benefits Committee. All parties involved will be notified in writing of the decision. Appeals should be mailed to the Benefits Administrator, City of Amarillo Group Health Benefit Plan, P.O. Box 15130, Amarillo, TX 79105-5130.

Payroll Deductions

The City of Amarillo Group Health Benefit plan has arranged with several healthcare providers to allow covered members to pay for their uncovered medical charges through payroll deduction. The minimum amount deducted per pay period is \$20.00. Call the Benefits Office, if you have questions regarding this benefit.

Baptist St. Anthony's Hospital (BSA), Quail Creek Surgical Hospital, Panhandle Surgical Hospital, Immediate Care Center, Panhandle Pediatrics, Family Medicine Centers in Amarillo and Canyon participate in payroll deductions.

Other Important Plan Provisions

Acts Of Third Parties and Subrogation/Reimbursement

By acceptance of payments or benefits under the Group Health Plan, You, the Covered Person agree as follows:

1. When a Covered Person, or a Covered Person's medical or dental provider receives payment from the Group Health Plan for any injury, condition, or illness for which another party may be responsible, the Group Health Plan shall be entitled to be reimbursed and, is also subrogated to all of the Covered Party's right of recovery against the responsible party for the entire amount of the payments made by the Group Health Plan for such injury or illness. This right of recovery by the Group Health Plan is contractual.
2. It is intended by the Group Health Plan that the phrases, "party may be responsible" "responsible party," "another party," or "responsible third party" include and mean:
 - (a) the responsible person or entity, the responsible person or entity's insurance carrier; and,
 - (b) the Covered Person's own insurance carrier and applicable coverages, specifically including uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, personal injury protection (if allowed by law), medical payments coverage, worker's compensation coverage, no fault automobile insurance coverage, or any other first party insurance coverage.
3. The term "Covered Person" includes anyone on whose behalf the Group Health Plan pays or provides any benefit, including but not limited to the employee and the spouse, minor children, dependent or legal representative of an employee.
4. If the Covered Person does not seek to recover damages from the responsible third party, then it is understood and agreed that the Group Health Plan may seek damages in the Covered Person's name for the Group Health Plan's benefit without any further consent from the Covered Person.
5. The Group Health Plan's right of reimbursement attaches, to fullest extent provided by law, to all amounts received by a Covered Person from any responsible party or any party making payment on such responsible party's behalf. By accepting benefits under the Group Health Plan, the Covered Person grants to the Group Health Plan an assignment of any proceeds received in any settlement, judgment, or other payment received by the Covered Person to the extent of one hundred (100%) of the amount of all benefits provided by the Group Health Plan on the Covered Person's behalf. This right to reimbursement is cumulative with and not exclusive of, the Group Health Plan's subrogation rights and the Group Health Plan may choose to exercise either or both rights of recovery.

As a Covered Person, you agree to:

- Notify the Group Health Plan in writing within ten (10) days after any injury, condition, or illness for which a third party may be responsible and for which the Group Health Plan has been used to pay for medical or dental diagnosis, tests, treatment or therapy; and
- Complete the Group Health Plan's Subrogation Form; and
- Cooperate with the Group Health Plan and do whatsoever is necessary to secure the Group Health Plan's right to subrogation and reimbursement; and
- Grant the Group Health Plan a first-priority lien on any recovery, settlement, judgment or other source of compensation which you receive or are entitled to as a result of and associated with of the injury, condition, or illness for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement) to the extent of one hundred percent (100%) of the amount paid by the Group Health Plan on behalf of the Covered Person.

- Pay the Group Health Plan, as the first priority, from any recovery, settlement, judgment or other source of compensation, up to one hundred percent (100%) of all amounts paid by Group Health Plan in association with the injury, condition, or illness for which another party is or may be responsible regardless of whether such payment or payments will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or compensate the Covered Person in part or in whole for the damages sustained; and
- Do nothing to prejudice (that is, harm) the Group Health Plan's rights set forth herein, such as making a settlement or recovery which reduces or attempts to reduce or exclude the full amount paid by the Group Health Plan on behalf of the Covered Person; and
- Serve as the constructive trustee for the benefit of the Group Health Plan as regards any funds received as a result of the injury, condition, or illness for which another party is or may be responsible.

It is intended hereby that:

- The Group Health Plan recover the full amount for all benefits paid without regard to any claim of fault attributable to the Covered Person, whether by comparative negligence or otherwise; and
- That the Group Health Plan recover one hundred percent (100%) of the amounts paid on behalf of the Covered Person and associated with the illness or injury which is or may have been caused by another party even if such recovery by the Group Health Plan will result in the Covered Person recovering an amount that is insufficient to make the Covered Person whole or fully compensate the Covered Person for the Covered Person's damages; and
- No court costs or attorney's fees may be deducted from the Group Health Plan's recovery and the Group Health Plan is not required to pay or contribute to paying court cost or attorney's fees for the attorney hired by the Covered Person to pursue the Covered Person's claim or lawsuit against a party that is or may be responsible for the Covered Person's injury or illness.

Failure of the Covered Member to cooperate with the Group Health Plan or to comply with the above provisions regarding Subrogation/Reimbursement may result in the following:

- Refusal by the Group Health Plan to pay claims associated with the injury or illness that was caused or may have been caused by a responsible third party; and/or
- Termination of employment by the City due to having a debt owed to the City in violation of the City Charter; and/or
- Responsibility for reimbursement to the Group Health Plan of all benefits paid by the Group Health Plan for the associated injury or illness including any costs and reasonable attorney's fees incurred by the Group Health Plan in obtaining reimbursement.

Recovery Of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Group Health Plan, the Group Health Plan has the right to recover these excess payments from any individual (including the covered member) insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by the covered member, the Group Health Plan will exercise their right to withhold payment on future benefits until the overpayment is recovered.

Right To Receive And Release Necessary Information

The Group Health Plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement Group Health Plan provisions. An individual requesting benefits, must furnish all the information required to implement the Group Health Plan provisions.

Inpatient Hospital Benefits

Network Inpatient Hospital Benefits

Baptist St. Anthony's Hospital (BSA) is the Plan's preferred provider for inpatient hospital stays and/or inpatient surgeries. Deductible amounts are waived for inpatient medical or surgical charges at BSA, Quail Creek Surgical Hospital and Physicians Surgical Hospital. This applies to the hospital charges only.

To qualify for maximum inpatient hospital benefits, it is necessary to precertify all inpatient stays and/or inpatient surgeries. The healthcare provider and/or the covered person must call the precertification number shown on the Plan identification card. A determination will be made within 48 hours and faxed to the provider. The number to call for precertification is (806) 342-1587.

The precertification request should be made 48 hours prior to admission for any non-emergency admission or surgery.

If emergency admission or surgery is required, a call must be made to the precertification number within 24 hours or the first business day after admission.

Example: *If you are hospitalized Saturday on an emergency basis, you or the provider must call the precertification number on Monday, even if you have been released from the hospital.*

Important: *The precertification process does not guarantee payment and the Plan may not pay for procedures or days not precertified. A list of the services that require precertification is found on page 37. Please advise your provider of the Plan's requirements for precertification.*

Out of Network Inpatient Benefits

Covered persons may choose to be admitted to another hospital for an inpatient stay and/or surgery; however, the Plan deductibles and out-of-pocket amounts for out-of-network hospitals are as follows:

- \$600.00 additional deductible per admission
- \$20,000.00 out-of-pocket, including the deductible, before the Plan pays at 100%

The Plan will pay covered charges from out-of-network hospitals at 80% of Medicare allowable rates. This means the Plan pays a reduced amount to the hospital and the hospital can bill the covered person for the difference in the billed amount and what the Plan pays. This could represent a considerable monetary penalty for the covered person.

Be aware of the way the Plan pays inpatient hospital stays and/or surgeries and advise your physician of the consequences for you of an admission to a non-network facility. Most physicians in the Amarillo area have privileges at both major hospitals.

If the Plan confirms a required inpatient surgery **cannot** be done at BSA, Quail Creek Surgical Hospital or Physicians Surgical Hospital, the covered charges will be paid as in-network and the standard deductibles and out-of-pocket amounts will apply.

Medical providers utilized by covered persons living or traveling outside a 130 mile radius of Amarillo will be paid as in-network and the standard deductibles and out-of-pocket amounts will apply.

Required medical services not available in the Amarillo area will be paid as in-network and the standard deductibles and out-of-pocket amounts will apply.

Emergency surgical procedures required for students who are attending college outside the 130 mile radius of Amarillo will be paid as in-network and the standard deductibles and out-of-pocket amounts will apply.

Covered hospital charges include those medical expenses which are medically necessary and incurred by a covered person, due to inpatient admission and/or surgery.

Examples of covered hospital charges:

- Semi private room, board and other hospital services required for treatment
- Additional charges for private rooms are the responsibility of the patient
- Intensive care units
- Blood transfusions and intravenous injections
- Storage charges for a covered person's own blood when it will be used for a medically necessary transfusion for the covered person only
- Cosmetic surgery, if needed due to accidental injury

Examples of non-covered hospital or surgery charges:

- Radial keratotomy or any other refractive surgery
- Cosmetic surgery except as noted in covered charges above
- Surgeries or procedures determined to be experimental by the Plan's Medical Director

Hospital Maternity Benefits

Routine hospital and physician charges for the newborn child in a network hospital are payable under the mother's coverage and subject to her deductible. Charges for treatment of the newborn associated with an illness are payable under the newborn's deductible.

Examples of covered hospital charges for the mother and newborn:

- Semi private room, board and other hospital services incurred by the mother
- Room and board charges, services and supplies for the newborn
- Hospital and physician charges for circumcision
- Routine visits by the newborn's physician during the hospital stay

Hospice, Home Health Care, and Nursing Home Benefits

Hospice Care Benefits

Home hospice care services, provided in accordance with a Hospice Care Program, are paid at 80% of contracted rates after the covered person's deductible has been met.

Hospice inpatient care will be considered and payable as any other hospital admission.

Bereavement counseling services, provided by a pastoral counselor, are available for the immediate family members (parents, spouse and children) of a covered person who was in a Hospice Care Program on the day immediately prior to his or her death. Counseling is limited to three (3) visits. Immediate family members receiving counseling must also be covered by the Plan.

Precertification is required for both inpatient and home hospice care.

Nursing Home Benefits

The Plan pays 50% of a semi-private room charge in a convalescent hospital, if admission occurs immediately following an acute care hospital stay of at least three (3) days. The Plan limits convalescent hospital benefits to 60 days per year.

Covered Home Health Care Services

- Part-time or intermittent nursing care by a registered nurse (RN) or a Licensed Practical Nurse (LPN), limited to two (2) hours during one 24 hour period. This limitation may be extended with approval of the Plan's Medical Director.
- Medical supplies, drugs and medications prescribed by a physician
- Laboratory services, which would have been covered, if hospitalized
- Limited to 40 visits per calendar year including skilled nursing care, and visits by home health aid. Visits may be extended with Medical Director approval.

Non Covered Home Health Services

- Custodial care
- Transportation services
- Any period during which the covered person is not under the continuing care of a physician

Physician Services, Outpatient Surgery,
Physical Therapy

Covered Physician Services

- Medical or surgical services performed or prescribed by a physician.
- Medical services prescribed by a physician and performed by a nurse.
- Charges of an assistant surgeon when considered medically necessary but limited to 20% of the allowable charge of the primary surgeon.
- Charges of a standby pediatrician, when requested by the attending physician and paid as an assistant surgeon.
- Services performed by an anesthesiologist or nurse anesthetist (CNA) or certified registered nurse anesthetist (CRNA).

Non-Covered Physician Services

- Any services rendered by a physician or nurse who resides in the covered person's household or who is related to the covered person including spouse, parent, stepparent, child, brother, sister, grandparents, aunt or uncle whether such relationship is by blood or exists by law.
- Services and/or supplies for which the covered person has no legal obligation to pay and/or for which no charge would be made in the absence of the covered person's benefit coverage under the Plan.

Second Opinion Coverage

- Physician charges for furnishing the second opinion. The physician must be a board certified internist or appropriate specialist and not associated with the physician recommending the second opinion.
- Charges for necessary testing done at the recommendation of the second opinion physician.

The Plan may request a second opinion before authorizing payment for any surgical or medical procedure and will pay 100% of the second opinion charges.

To view the physicians who are in-network for the city plan go to the following website:

<http://www.bsahs.org/body.cfm?id=11>

You may also call the Benefits office at 378-4235 for physician questions.

Outpatient Surgery

Outpatient surgery (day surgery) hospital charges are paid at 100% with no deductible when the surgery is performed at BSA, Quail Creek Surgical Hospital or Physicians Surgical Hospital. **Outpatient surgery must be precertified.** Physician charges are subject to deductible and out-of-pocket amounts.

There may be some outpatient surgery procedure charges paid at 100% in other facilities. Please check with the Benefits office, if you have questions about how an outpatient surgery will pay.

Outpatient surgeries performed at non-network facilities are paid at 80% of Medicare allowable which is a reduced rate and could cause you to incur additional expense.

Physical Therapy

Covered Physical Therapy Services

- Services provided by a physical therapist when prescribed by a physician.
- Restorative or rehabilitative speech therapy services performed by a licensed speech therapist and required for speech loss or impairment due to an illness or accidental bodily injury.

Non-Covered Therapy Services

- Occupational therapy services
- Speech therapy for loss or impairment due to mental disorders

The Plan's network provider for physical therapy services is BSA. Please advise your physician when physical therapy services are needed. Physical therapy done at a non-network facility will be paid at 80% of Medicare allowable rates.

Laboratory, Radiology, Transplant and Other Miscellaneous Covered Medical Services

Laboratory Services

Charges for laboratory services i.e., blood chemistries, urinalysis, complete blood count (CBC), are paid at **100%, without regard to deductible**, when they are done at:

Physicians Preferred Laboratory

or if your physician is in one of the following facilities:

**Amarillo Diagnostic Clinic
Amarillo Family Physicians
BSA Urgent Care Center
Family Medicine Centers of Amarillo and Canyon
Panhandle Pediatrics
Immediate Care Center
CityCare**

Charges for laboratory services done in a facility other than those listed above will be paid at 90% of the Plan's contracted rate.

NOTE: Charges for drawing blood are not covered by the Plan, unless the physician is sending the specimen to an outside laboratory for testing.

Radiology Services (X-ray)

The Plan's network provider for MRI's, and CT scans is Baptist St. Anthony's Hospital (BSA)

Members receiving treatment at CityCare will be referred to Open Air MRI for **routine x-rays** and there will be no charge to the member.

MRI's and CT Scans must be precertified. Call (806) 342-1587 for the nurse.

Covered Transplant Services

- Services and supplies incurred in connection with the following human to human transplant procedures:

Cornea	Heart or heart-lung	Bone marrow	Kidney
Liver	Pancreas	Stem cell	
- Those medical services incurred by the donor, if the donor is covered under the Plan. Benefits for recipient and donor will be treated separately, if both are covered by the Plan
- Services for a donor not covered by the Plan will be considered for payment following payment by the donor's plan.
- The usual and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a hospital's charge for storage and/or transportation of the organ

Non Covered Transplant Procedures

Those transplant procedures determined by the Plan's Medical Director to be experimental or research in nature

Travel and accommodations

Other Miscellaneous Covered Medical Services

- Medical treatment by x-ray, radium, radioactive isotope therapy, cobalt and chemotherapy
- Treatment for complications caused by the use of birth control devices
- Cosmetic surgery, if due to a functional condition or to correct an accidental injury
- Mammoplasty, plastic surgery of the breast, following a partial or full mastectomy provided the mastectomy was performed while covered under the Plan
- Accidental injury to sound natural teeth including replacement of the injured teeth within twelve (12) months of the accident, if accident occurred while a covered person
- Care, treatment, surgery or dental appliances for repair or alleviation of a congenital cleft palate.
- Required childhood immunizations are paid at 100% to age six (6)
- Sterilization procedures
- Ambulance services, including ground or air, when medically necessary
- Services provided by a Chiropractic Physician for the detection and correction by manual or mechanical means (including x-rays) of structural imbalance, distortion, or subluxation in the human body for the removal of nerve interference caused by or related to distortion, misalignment or subluxation of or in the vertebral column not to exceed the percentage payable and maximums stated in the Schedule of Benefits.
- Initial glasses (including contact lens) if required following cataract surgery

Mental Health Services

All mental health services must be precertified through the City's precertification nurse. The number to call is **(806) 342-1587**. If you schedule mental health services without contacting the precertification nurse, the services may not be paid. Mental health services are never paid at 100%.

Covered mental health benefits

- Services that are medically necessary for symptom management and will behaviorally make a difference in the covered person's condition or disorder
- Outpatient sessions are limited to 25 per year. Limitation may be extended with approval of the Medical Director
- Inpatient days are limited to 30 per year

After 12 sessions the case may be subject to review by the Plan's Medical Director.

Examples of Some Non Covered Mental Health Services

- Pastoral counseling (except as covered under Hospice care)
- Sex therapy
- Personality disorders
- Services of a marriage counselor
- Other social services

The above services may be provided by the Employee Assistance Program (EAP). You may go to the EAP counselor 3 times at no charge and anonymously. If the EAP determines a need for further counseling, following the 3 sessions provided at no charge and the employee or dependent is covered by the Health Plan, the counselor will refer the patient to an in-network provider. For more information regarding the EAP, call the Benefits office at 378-4235.

Durable Medical Equipment

Durable Medical Equipment (DME) is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. The Plan uses the criteria outlined in the Medicare Carriers Manual, Part 3, to determine necessity and reasonableness of DME.

Benefits are paid for the rental of medically necessary durable medical equipment (DME) on a temporary basis for 6 months or less. If the purchase price is less than the rental fee, the DME will be purchased. **Precertification is required for DME in excess of \$125.00 per item.**

Examples of Covered DME

- Oxygen and necessary supplies and equipment for its administration
- Braces, splints
- **Initial** prosthetic appliances, if the loss or impairment occurred while covered under the Plan
- Wheel chairs (standard)
- Hospital beds (standard)
- Crutches, canes, walkers

IMPORTANT: Replacement of any DME will be considered only in the case of physiological change or accidental destruction. Repair and maintenance of DME will not be considered.

Examples of Non-Covered DME

- Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient
- Televisions, telephones
- Guest meals or cots
- Air conditioners, air filters, humidifiers, cooling or heating equipment
- Orthopedic mattresses, allergy free pillows, blankets and/or mattress covers
- Non-hospital adjustable beds or waterbeds
- Purchase, rental or modification of motorized transportation equipment including lifts, elevators, escalators or ramps
- Structural changes to a house including tub rails and shower benches
- Sauna or whirlpool equipment
- Swimming or therapy pools
- Exercise equipment
- Vibratory equipment
- Health club memberships
- Massage therapy or hippotherapy
- Speech teaching machines
- First aid or precautionary type equipment

Precertification Requirements

Please call or have your provider call the City of Amarillo's precertification line, **(806) 342-1587**, if any of the following services are scheduled. **Failure to precertify may result in a monetary penalty and/or a reduction in your benefits.** All the procedures listed below should be precertified **48 hours prior** to the scheduled procedure, if not an emergency.

- Non-emergency hospitalization
- Elective surgery - inpatient and outpatient
- MRI
- CT scan
- PET scan
- Salpingogram
- Pain management/therapy
- Physical therapy
- Durable medical equipment in excess of \$125.00 per item
- Radiation or chemotherapy treatment
- Hospice care
- Home health care
- Dialysis
- IVP
- Cystoscopy
- Thallium stress tests
- Echocardiograms
- Mylograms
- Breast reconstruction
- Outpatient cardiac rehabilitation
- Colonoscopy
- Endoscopy
- Chiropractic treatment
- Sleep studies
- Angiogram

All mental health services, including chemical dependency treatment, must be precertified. The number to call for precertification of mental health services is (806)342-1587.

Prescription Drug Coverage

The City of Amarillo offers its covered members a prescription drug program which enables purchase of prescriptions with a four tiered formulary plan. Enclosed in the pocket of this handbook is a copy of the formulary and a brochure outlining the pharmacy program from the Plan's pharmacy benefit management company, MaxorPlus. **There are certain prescription drugs that are not covered by the Plan with a copay but may be purchased with the Plan's discounted rate.** If you have a question about a prescription drug you may call the Benefits Office at 378-4235 or Maxor at (806) 324-5500 or 1-800-687-8629. The copay amounts for a 30 day retail supply of covered drugs are as follows:

- Tier 1 Generic drugs \$10.00 per prescription
- Tier 2 Brand name drugs on the formulary \$35.00 per prescription
- Tier 3 Brand name drugs **not** on the formulary with **no** generic equivalent available are \$50.00 per prescription
****Brand name drugs not on the formulary with a generic equivalent available are \$50.00 plus the difference in cost between the generic and the brand name**
- Tier 4 Specialty drugs \$65.00 per prescription

Mail order prescription service for maintenance drugs is available through the MaxorPlus mail order pharmacy located at 2nd and Polk in Amarillo. If your prescription is considered a maintenance drug, you can save a copay by ordering through Maxor's mail order pharmacy. Your physician must write the prescription for a 90 day supply and submit it to Maxor. The copay amounts for a 90 day supply through mail order are:

- Tier 1 Generic drugs \$20.00 per 90 day prescription
- Tier 2 Brand name drug on the formulary \$70.00 per 90 day prescription
- Tier 3 Brand name drugs not on the formulary with no generic equivalent available \$100.00 per 90 day prescription
****Brand name drugs not on the formulary with a generic equivalent available are \$100.00 plus the difference in cost between the generic and the brand name per 90 day prescription**
- Tier 4 Specialty drugs \$130.00 per 90 day prescription

Most pharmacies in the Amarillo area are in the Maxor pharmacy network. See the brochure in the pocket of your handbook for more details.

Plan Exclusions and Limitations

No benefits are payable under any part of the Plan with respect to any charges:

- For expenses incurred for services rendered prior to the effective date of coverage under the Plan;
- For which a covered person is not financially responsible or for discounts which the covered person is not responsible, including but not limited to independent and preferred provider discounts;
- Not medically necessary for diagnosis or treatment of an illness or injury as determined in consultation with the Plan's Medical Director;
- For expenses applied under this Plan toward satisfaction of any deductibles, copayments, copayment percentage or access charge;
- In excess of the usual, reasonable and customary fees for services and supplies;
- For any injury or illness for which the claimant is not under the regular care of a physician or does not follow the attending physician's treatment plan;
- For any injury, illness or disability resulting from or sustained as a result of war or act of war, declared or undeclared;
- Resulting from a self-inflicted injury or attempted voluntary self-destruction while sane or insane;
- For any injury, illness, or disability expense resulting from injury caused by participating in civil insurrection or riot;
- For any injury, illness or disability resulting from or sustained as a result of being engaged in an illegal occupation or the commission of or the attempted commission of an illegal act;
- For any illness, injury, or disability as a result of or in the course of any occupation or employment where the intent is to earn a wage or profit even if such illness, injury, or disability is not covered by Workers' Compensation;
- For any injury, illness, or disability to members of the armed forces of the United States or a State from or sustained as a result of war or act of war, declared or undeclared. In the event of mass casualties to civilians, benefits may be denied or reduced based on the Plan's ability to pay;
- For any illness, injury or disability which would entitle the covered person to any benefit under Workers' Compensation;
- For expenses for preparing medical reports, itemized bills, or claim forms and mailing and/or shipping charges;

- For broken/missed appointments or telephone calls;
- For eye examinations for the purpose of prescribing corrective lenses or determining visual acuity or for treatment of refractive errors, eye glasses or contact lenses (including the fitting thereof), orthoptics, vision therapy, or other special vision procedures including radial keratotomy;
- For services incurred in connection with remedying a condition by means of cosmetic surgery or reconstructive surgery;
- For the non-surgical treatment of
 1. weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions
 2. corns, calluses or toenails;
- For over-the-counter shoe inserts;
- For vocational evaluation, rehabilitation retraining;
- For transportation expenses or accommodations;
- For repair and maintenance or replacement of durable medical equipment except when necessitated by physiological changes or accidental destruction, subject to approval by the Group Benefits Administrator;
- For home health care expenses that are for:
 1. custodial care
 2. transportation services
- any period during which the covered person is not under the continuing care of a physician;
- For private duty nursing care;
- For wigs and artificial hairpieces;
- For sex therapy, outpatient group family therapy, marriage counseling, or any other social services unless otherwise specified;
- For services in connection with infertility including but not limited to artificial insemination, in-vitro fertilization or any charges for actual or attempted impregnation which involves either a covered person or a surrogate acting as a donor or a recipient;
- For adoption expenses;
- For elective abortions for covered persons except in the case of incest, rape, or situations which are life threatening to the mother;

- For all services related to intersex surgery (transsexual operations) and any resulting complications;
- For surgical procedures to reverse sterilization;
- Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, including but not limited to the purchase or rental of telephones; television; guest meals or cots; orthopedic mattresses; allergy-free pillows, blankets and/or mattress covers; non-hospital adjustable beds; waterbeds; structural changes to a house including tub rails, and shower benches; first aid or precautionary equipment; purchase, rental or modification of motorized transportation equipment, including lifts, elevators, escalators or ramps;
- For air purification humidifying, cooling or heating equipment;
- For exercise equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy or hippotherapy;
- For services or supplies rendered to any covered person for treatment of severe clinical obesity or for weight reduction;
- For medically necessary or non-medically necessary surgical procedures for obesity;
- For services incurred in connection with acupuncture or acupressure;
- For educational testing, speech training machines, hypnosis, biofeedback, recreational therapy or any behavior modification therapy;
- For spinograph or thermography;
- For nicotine addiction or for any treatment, service or supply incurred or any therapy or training designed to curb or alleviate a personal habit except to the extent it is covered as a pharmacy benefit;
- For any non surgical treatment of the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances or splints or alteration of the occlusal relationship of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent muscles and nerves;
- For dental care or treatment to the teeth, alveolar processes, gingival tissue, or for malocclusion;
- For drugs and medicines lawfully obtainable without a physician's prescription (even if prescribed by a physician) including but not limited to vitamins, cosmetics, dietary supplements, and over the counter home tests;
- For prescription drugs dispensed on an outpatient basis which are covered under a fixed co-payment prescription drug card program (including co-payments and any required payment differentials between generic and brand name drugs);

- Expenses for treatments, procedures, drugs or devices which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigational or done primarily for research, including but not limited to the following:
 - 1) it fully involves the use of a drug, substance or device that has not been approved by the United States Food and Drug Administration; or
 - 2) reliable evidence shows the following:
 - a) the treatment, procedure, device or drug is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment for diagnoses; and
 - b) the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment for diagnoses.

Reliable evidence includes anything determined to be such by the Plan Administrator, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

- For hearing aides, repair of hearing aides, hearing examinations or related supplies unless loss of hearing is due to a covered illness or accidental injury;
- For services rendered by any of the following relatives:
 - spouse
 - parent(s), step-parent(s), parent(s) in law
 - child(ren) or child(ren) in law
 - brother(s) or brother(s) in law
 - sister(s) or sister(s) in law
 - grandparent(s) or grandparent(s) in law
 - aunt(s) or uncle(s) or aunt(s) or uncle(s) in law
- For any injury, illness or disability resulting from participation in the following hazardous activities:
 - bungee jumping
 - hang gliding
 - sky diving
- Submitted more than 90 days after the date incurred unless the covered person is legally incapacitated;
- Services or treatments that are excluded under any part of this Plan.

Exemption Election, COBRA Notice, Notice of
Privacy Practices, USERRA, Grandfathered
Plan Status, Early Retiree Reinsurance
Program Notice

NOTICE TO HEALTH PLAN PARTICIPANTS

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The City of Amarillo has elected to exempt the City of Amarillo Group Health Plan from the following requirements:

Limitations on preexisting condition exclusion period

Special enrollment periods for individuals (and dependents) losing other coverage

Prohibitions against discriminating against individual participants and beneficiaries based on health status

Standards relating to benefits for mothers and newborns

Parity in the application of certain limits to mental health benefits

Required coverage for reconstructive surgery following mastectomies

The exemption from these Federal requirements will be in effect for the Plan year beginning January 1, 2011 and ending December 31, 2011. The election may be renewed for subsequent Plan Years. The entire Plan is subject to this exemption.

Because of the election:

- Employees and dependents will be subject to benefit limits even if they had 12 or 18 months of coverage under another plan within the last 63 days.
- Even though the Plan is exempt, employees and dependents will be able to enroll if they have a qualifying event during the Plan year as set out in the benefits booklet. The Plan's qualifying events are more liberal than the Federal Law.
- No individual will be charged a higher rate based on a medical condition
- The duration of a hospital confinement for a mother and newborn following the birth of a child will be determined based on medical necessity.
- Mental health benefits are subject to annual visit limitations.
- Breast reconstruction following a covered mastectomy will be paid as allowed within Plan parameters.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy. If you have questions regarding any of the information contained in this notice, you may contact the Benefits Administrator by telephone at 806-378-9379 or by mail at City of Amarillo Group Health Plan, P.O. Box 15130, Amarillo, TX, 79105-5130.

COBRA CONTINUATION COVERAGE

Introduction

You are receiving this notice because you have recently become covered under the City of Amarillo Group Health and Dental Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you may contact the City of Amarillo Group Health and Dental Plan, Benefits Administrator at 806-378-4235.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;

- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 90 days after the qualifying event occurs. You must provide this notice to: City of Amarillo Group Health and Dental Plan, Benefits Administrator, 509 S.E. 7th, Room B6, 806-378-4235 and verification of the qualifying event is required.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Documentation of the disability must be submitted to the Benefits Administrator at P.O. Box 15130, Amarillo, Texas, 79105-5130 within 30 days of the disability determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Premium Reduction

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. ARRA has been amended three times: on December 19, 2009 by the Department of Defense Appropriations Act, 2010, on March 2, 2010 by the Temporary Extension Act of 2010, and on April 15, 2010 by the Continuing Extension Act of 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the Group Health Plan.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010;¹
- MUST elect the coverage;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.²

¹ The involuntary termination must occur on or after March 2, 2010 but by May 31, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring from September 1, 2008 through May 31, 2010.

² Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

IMPORTANT

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you **MUST** notify the Group Health Plan in writing. If you do not, you may be subject to a tax penalty.
- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov

For specific information related to the Group Health Plan's administration of the ARRA Premium Reduction or to notify the Group Health Plan of your ineligibility to continue paying reduced premiums, contact the Group Health Plan Administrator.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

Keep the Plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

City of Amarillo Group Health and Dental Plan
Benefits Administrator
P.O. Box 15130
Amarillo, TX 79105-5130
806-378-4235
Fax 806-378-9488

City of Amarillo Group Health Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice is January 1, 2003.

The City of Amarillo Group Health Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the following:

- the Plan's uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section I Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The City of Amarillo as the Plan Sponsor, has amended the Plan documents to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that

notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- When required for law enforcement purposes (for example, to report certain types of wounds).
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to conditions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Section II. Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI.

“Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

“Designated Record Set” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed, if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed, if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated records set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed, if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated records set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the compliance date.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12 month period, the Plan may charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (members and dependents) with notice of its legal duties and privacy practices.

This notice is effective beginning January 1, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all members and dependents for whom the Plan still maintains PHI. The revised notice will be sent via mail to the members or dependents home address.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;

- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan sponsor for determination of premium amounts, modifying or amending the group health plan, for summarizing the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have questions regarding this notice or the subjects addressed in it, you may contact to Cindy Reynolds, Benefits Administrator/Privacy Officer, P.O. Box 15130, Amarillo, TX, 79105-5130, 806-378-9379.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

<p>Your Rights Under USERRA The Uniformed Services Employment And Reemployment Rights Act</p>
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Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at [Http://www.dol.gov/vets](http://www.dol.gov/vets). An interactive online USERRA Advisor can be viewed at [HTTP://www.dol.gov/elaws/userra.htm](http://www.dol.gov/elaws/userra.htm).

For further information on reemployment rights under USERRA contact the Human Resource office at 378-4296.

Grandfathered Plan Status

The City of Amarillo believes that the Group Health Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “PPACA”). As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Group Health Plan may not include certain consumer protections of the PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA, for example, the elimination of lifetime limits on certain essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be direct to the Plan Administrator (see below). You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants’ premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose.

A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

You are responsible for providing a copy of this notice to your family members who are participants in this plan.

Definition of Terms

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this Plan.

Accident

An unforeseen and unavoidable event resulting in an injury, which is not due to any fault of the covered person.

Actively at Work (Active Employment)

You are considered to be actively at work when performing in the customary manner all of the regular duties of your occupation with the employer, either at one of the employer's regular places of business or at some location to which the employer's business requires you to travel to perform your regular duties or other duties assigned by your employer. You are also considered to be actively at work on each day of a regular paid vacation or non-working day on which you are not totally disabled, but only if you are performing in the customary manner all of the regular duties of your occupation with the employer on the immediately preceding regularly scheduled work day.

Age Discrimination

A violation of the Social Security Act, which states that all active employees and their covered dependents age 65 and over are entitled to the same and/or equal benefits they had prior to age 65.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of physicians; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Amendment (Amend)

A formal document signed by the representatives of City of Amarillo. The amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

Benefit Year

The 12-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.

Birthing Center

A public or private facility, other than private offices or clinics of physicians, which meets the free-standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in an area hospital; at least 2 beds or 2 birthing rooms; full-time nursing

services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

Chiropractic Services

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Complications of Pregnancy

Conditions (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy such as: acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include a non-elective caesarean section, an ectopic pregnancy which is terminated, or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy).

Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions which, although associated with the management of a difficult pregnancy, are not medically classified as distinct complications of pregnancy.

Cosmetic Surgery

A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an illness or injury.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a health care provider.

Diagnostic Charges

The usual and customary charges for x-ray or laboratory examinations made or ordered by a physician in order to detect a medical condition.

Durable Medical Equipment

Durable Medical Equipment is equipment, which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

Elective Hospital Admission

Any non-emergency hospital admission, which may be scheduled at the patient's convenience without jeopardizing the patient's life or causing serious impairment.

Eligible Independent Contractor

An independent contractor that manages a City-owned facility, but excluding any tenants and concessionaires, as determined by the Plan Administrator in its sole discretion.

Employer

City of Amarillo and Related Affiliates.

Health Care Provider

A physician, practitioner, nurse, hospital or specialized treatment facility as those terms are specifically defined in this section.

Home Health Care Agency

A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one physician and one registered graduate nurse to supervise the services provided.

Home Hospice

A program, licensed and operated according to the law, which is approved by the attending physician to provide palliative, supportive and other related care in the home for a covered person diagnosed as terminally ill.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill.

The facility must have an interdisciplinary medical team consisting of at least one physician, one registered nurse, one social worker, one volunteer and a volunteer program.

A hospice facility is not a facility or part thereof which is primarily a place for rest, custodial care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

A public or private facility, licensed and operated according to the law, which provides care and treatment by physicians and nurses at the patient's expense of an illness or injury through medical, surgical and diagnostic facilities on its premises.

A hospital also includes tuberculosis facilities, mental/nervous treatment facilities and substance abuse treatment facilities, which are licensed and operated according to the law. A hospital does not include a facility or any part thereof, which is, other than by coincidence, a place for rest, the aged, or convalescent care.

Illness

Any bodily sickness, disease or mental/nervous disorder. For purposes of this Plan, pregnancy will be considered as any other illness.

Injury

A condition which results independently of an illness and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward or wing within a hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate nurses or other highly trained personnel. This excludes, however, any hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Lifetime

The period of time member or eligible dependents participate in this Plan or any other plan sponsored by City of Amarillo.

Maintenance Care

Services and supplies provided primarily to maintain a level of physical or mental function.

Medical Emergency

An illness or injury which occurs suddenly and unexpectedly, requiring immediate medical care and use of the most accessible hospital equipped to furnish care to prevent the death or serious impairment of the covered person.

Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

Medically Necessary (Medical Necessity)

Any non-experimental service or supply required for the diagnosis or treatment of an active illness or injury that is rendered by or under the direct supervision of the attending physician, generally accepted by medical professionals in the United States.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Mental/Nervous Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation, and effective treatment of mental/nervous disorders; and, professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility must have a physician on staff or on call.

The facility must also prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Oral Surgery

Necessary procedures for surgery in the oral cavity, including pre- and post-operative care.

Outpatient

Treatment either outside of a hospital setting or at a hospital when room and board charges are not incurred.

Physically or Mentally Disabled

The inability of a person to be self-sufficient as the result of a condition such as mental disability, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a physician as a permanent and continuing condition.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The Plan Administrator, City of Amarillo, who is the sole fiduciary of the Plan, has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law. All decisions made by the Plan Administrator shall be final and binding on all parties.

City of Amarillo may choose to hire a consultant and/or contract administrator to perform specified duties in relation to the Plan. The Plan Administrator also has the right to amend, modify or terminate the Plan at any time or in any manner.

Plan Sponsor

City of Amarillo.

Plan Year

The 12 month fiscal period for City of Amarillo beginning January 1 and ending December 31.

Practitioner

A physician or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Advanced Clinical Practitioner (A.C.P.) and other practitioners working with the City's Employee Assistance Program and on file.

Preferred Providers

Those health care providers who have contracted with City of Amarillo to provide certain services for which benefits are considered at special levels.

Psychiatric Day Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than 8 hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and, supervision by a physician certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Regular Employee

A person employed by the Employer whose customary work week is forty (40) or more hours per week on a year round basis.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Relatives are defined as one of the following:

- spouse
- parent(s), step-parent(s), parent(s) in law
- child(ren) or child(ren) in law
- brother(s) or brother(s) in law
- sister(s) or sister(s) in law
- grandparent(s) or grandparent(s) in law
- aunt(s) or uncle(s) or aunts(s) or uncle(s) in law;

Related Affiliate

The Amarillo Economic Development Corporation (AEDC) and the Amarillo City Federal Credit Union.

Second Surgical Opinion

Examination by a physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility

A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered nurse or physician on full-time duty in charge of patient care; at least one registered nurse or practical licensed nurse on duty at all times; a daily medical record for each patient; transfer arrangements with a hospital; and, a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their illness or injury, and is not, other than by coincidence, a rest home for custodial care or for the aged.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include birthing centers, psychiatric day treatment facilities, ambulatory surgical facilities, hospice facilities, skilled nursing facilities, rehabilitation facilities, mental/nervous treatment facilities or substance abuse treatment facilities as those terms are specifically defined.

Substance Abuse Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation, and effective treatment of substance abuse; detoxification services; and professional nursing care provided by licensed nurses who are directed by a full-time R.N. The facility must have a physician on staff or on call. The facility must also prepare and maintain a written plan of treatment for each patient based on medical, psychological and social needs.

Surgery

Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision.

Third Surgical Opinion

Examination by a physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery to evaluate the medical advisability of undergoing a surgical procedure.

Total Disability (Totally Disabled)

The inability to perform all the duties of your occupation with the City of Amarillo or any other type of work for wage or profit as the result of a non-occupational illness or injury. A dependent will be considered totally disabled if, because of a non-occupational injury or illness, he or she is prevented from engaging in all the normal activities of a person of like age who is in good health.

Usual and Customary Charge

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other physicians.